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## PAYMENT OVERVIEW

The Adult Services Authorized Payments (ASAP) is the payment system that processes adult services authorizations. The adult services worker enters the payment authorizations using the payment module in the MiAIMS system.

- Warrants are delivered to the licensed provider each month after they enter a claim in the ASAP system for residents in their facility.
- Payments can be a full or partial month for reasons of temporary absence from the facility (such as nursing home rehabilitation or hospital stay).
- The claim must be entered in ASAP using the same begin and end dates of the authorization entered in MiAIMS or the payment will not be processed.
- If at any time a warrant is not received or is missing, the worker must follow the process to have the payment reissued; see ASM 160.
- If the warrant was paid in error, the adult services worker must follow the recoupment process; see ASM 165.

## Funding Sources

The payments have two different funding sources depending on the needs of the residents.

1. Payments for residents who need personal care services provided in licensed Adult Foster Care (AFC), County Infirmaries (CI) and Home for the Aged (HFA) are funded by Title XIX Medicaid funds.
2. Payments for residents who are not in need of personal care services but do need the supervision provided in licensed AFC, County Infirmaries and HFA are funded by state dollars - General Fund/General Purpose (GF/GP).

### ***Title XIX***

The information on the assessment helps determine the funding source of the personal care supplement payment. If there is a limitation noted in at least one of the Activities of Daily Living (ADL)

that is ranked a **level 2**, 3, 4, or 5, the adult services worker needs to have the client's physician complete a DHS-54A, Medical Needs form. The physician certifies there is a need for personal care by checking yes on the form. The DHS-54A physician signature date must be entered in MiAIMS to direct the personal care supplement payment dispersing out of Title XIX funds.

For Medicaid clients residing in a license facility, it is not necessary to delay entry of the initial authorization of payment while waiting for the DHS-54A to be obtained. The initial authorization may be put on the system for a short duration (90 days or less) when state funds are used for the payment.

**Note:** The adult services worker must remember to change the authorization once the DHS-54A is received by entering the date the physician signed and approved the need for personal care in the Medical tab in MiAIMS. If state funds were the source, end date that authorization and enter the new DHS-54A date. The ASAP payment system will switch payment to Title XIX funds to pay the licensee provider for services.

### ***State Funded***

State funds are used when the client is on Medicaid and has no ADL needs or medication requirements. The personal care supplement is paid using state funds. The DHS-54A form signed by the physician that states no means the 54A date is **not** entered in MiAIMS.

## **Payment Authorizations**

Licensed AFC homes, County Infirmaries and HFA residents who are Medicaid recipients are eligible for the personal care supplement payment from either GF/GP state funds prior to the obtaining of a DHS-54A, or from federal Title XIX funds after receipt of a DHS-54A stating the resident requires personal care.

### ***Initial Authorization in MiAIMS***

The adult services worker will search under the payment module/provider tab in MiAIMS for the AFC/HFA provider. The provider must be assigned to the open ACP case so the personal care supplement payment can be authorized. Authorizations will error out unless there is an active service case in the ACP program and an open Medicaid case with a scope of coverage of 1F, 2F, or 3G.

The pay begin and end dates establish the duration of an authorization. Authorizations can be for one day, a partial month, a full single month, retroactive months or extended up to six months to the next review.

The initial begin date for an authorization will typically be the date the client entered the facility. If the client was not Medicaid eligible at the time of admission, the authorization begin date will be the date the client became eligible for Medicaid.

### ***Updates to Payment Authorizations***

After the initial authorization, the adult services worker will update the payment authorization at the review. If all information on the client and the provider remain the same, a new authorization is put on MiAIMS.

If there is a change in provider, the client moves, or there is a break in services such as hospitalization, the authorization must be terminated with an end date. Each example is explained below:

- **Hospitalization.** When a client is hospitalized more than 24 hours, the adult services worker must stop payment. Medicaid pays the hospital from the date the client enters the hospital through the day prior to discharge. The AFC facility is then paid from the date of discharge.

**Example:** The client enters the hospital on 5-18-2016. The AFC would be paid through 5-17-2016. The adult services worker enters 5-17-2016 as the stop date of payment to the AFC. The hospital will bill Medicaid for the day the resident entered the hospital. When the client returns to the AFC from the hospital, the day of return to the AFC can be entered for the AFC to begin billing.

- **Temporary Absence Other Than Hospital.** Absences up to 104 days a year are permissible without an adverse effect on the AFC-HA personal care supplemental payment. This will eliminate a potential disincentive and encourage family visits, weekends or vacation time away from the facility. Providers will need to record the dates of absences in the facility resident record and adult service workers will monitor this at the time of the six month and annual redeterminations. Absences of more than 8 days a month, but less than 104 days a year must be approved by the Adult services worker and supervisor.

***Payments automatically stop***

Personal care supplemental authorizations (code 0401) will automatically stop for the following reasons:

- Authorization end date is reached.
- Services case closes.
- Medicaid eligibility ends.
- The AFC/HFA provider's license ends.
- Program Enrollment Type (PET) code error.
- Medicaid benefit program code is not eligible.

***Payments on closed cases***

An authorization can be completed on a closed case for a time period the case was open, Medicaid was active, and the provider was assigned to the case. A supervisor will need to approve this authorization.

**Note:** If the provider was not assigned prior to the case closure, contact the Supportive Adult Services Section for assistance via the policy email box at: [MDHHS-Adult-Services-Policy@michigan.gov](mailto:MDHHS-Adult-Services-Policy@michigan.gov). Please enter **ACP** in the subject line.

***Central Office payment exceptions***

The following payment authorizations will pend via MiAIMS to central office for processing:

- Authorization period is more than six months prior to the current date. Payments within six months or future authorizations must be approved locally and cannot be approved as an exception. If the adult services worker has a retroactive payment request that spans six months and beyond the current date (no more than 365 days prior to the current date), the request must be split into two different authorizations.

**Example:** Today's date is July 24th and your licensed facility is requesting Title XIX personal care payments from the date the adult moved in, which was the month of July of the prior year. There would be two payments entered in MiAIMS, one being July through December 31 (which would first be approved by your local supervisor and then pended to central office), and the second request from January 1 to the July 24th (which would be approved by your supervisor only).

- Authorizations that occur during the same time period as other adult services program (for example, Adult Protective Services payment and ACP payment). The authorization submitted to central office must only be for the time period the programs overlap.

**Example:** An APS payment was requested for living cost for a client who moved into an AFC facility November 1st through the 30th. An ACP case was opened also because the client qualifies for Medicaid, has personal care needs, and will remain at the facility permanently. The authorization to central office must reflect the overlap period of November 1 to the 30th on each request.

**Example:** An APS authorization was entered first will be approved by local office. The secondary ACP authorization will pend to central office for approval and vice versa.

- Cases that are closed in MiAIMS but were open and active during the authorization period requested.
- The authorization is for a provider in a service period for which another provider has received an erroneous payment.
- Cases where an administrative error occurred. These exceptions must be approved by a local office director or designee in addition to the supervisor.

All payment exception requests sent to the supervisor and central office must have adequate justification explained in the rationale box in MiAIMS with details as to why an exception is required.

If clear explanation is not provided with the exception, the payment request will be either delayed with central office asking for clarification or the request will be denied.

Payment authorizations approved by central office will contain the number 9 before the service code (9301, 9302, or 9401) on the payment line in MiAIMS. When the payments are approved or denied, the adult services worker will receive a confirmation E-mail.

### **ASAP Licensee Monthly Billings**

The AFC/HFA licensee must complete the following steps to bill for the monthly MA personal care supplement:

- Register online in the Statewide Integrated Governmental Management Applications (SIGMA) at [www.michigan.gov/SIGMAVSS](http://www.michigan.gov/SIGMAVSS).
- Be enrolled in Bridges and obtain a provider ID number.
- Obtain a personal identification number (PIN) to allow access to the Adult Services Authorized Payment system (ASAP). To obtain a PIN, the licensee must call the Provider Support line at 1-800-979-4662.

AFC/HFA licensed providers will submit claims for services rendered each month either by phone or online. If submitting billings online, the licensee must create an account through MiLogin at <https://milogintp.michigan.gov> and subscribe to the Adult Services Automated Payments (ASAP) application. To bill via telephone, the provider must call 1-800-798-1409.

**Note:** For information on how to enroll in MiLogin refer providers to [the Provider Support line at 1-800-979-4662](https://milogintp.michigan.gov).

The services dates authorized by the adult services worker must match what the provider is billing, or no payment will be issued.

Web or phone billing access is available 24 hours a day, 7 days a week.

All months with partial service dates will result in a prorated payment to the AFC/HFA.

AFC/HFA providers will be issued a 1099 form each January; see ASM 145.

## WARRANTS OVERVIEW

Please see **ASM-160** for complete step-by-step instructions for warrant replacement or cancellation procedures.

### Resolving Payment Issues

Reasons for non-payment may be the result of the following:

- An incomplete or incorrect claim submitted by the licensee in ASAP.

- Incorrect dates entered for the service period. The dates submitted on the claim must match the authorization in MiAIMS.
- Change in the licensee status from the Bureau of Community and Health Systems (BCHS)

To assist in determining a payment issue, the adult services worker should do the following:

- Review the licensee information shown in MiAIMS for incorrect mailing information, tax ID, or payment authorization time periods.
- Verify with the licensee that they are registered in SIGMA .

If the adult service worker is unable to resolve the problem after following these directions, they should send an email to the Supportive Adult Services Section at [MDHHS-Adult-Services-Policy@michigan.gov](mailto:MDHHS-Adult-Services-Policy@michigan.gov) for additional assistance. In the email subject line enter **ACP Payment Issue**.

## Recoupment

The MDHHS Medicaid Collections Unit (MCU) is responsible for recoupment of overpayments for the Adult Community Placement program. The adult services worker is responsible for notifying the AFC/HFA provider in writing of the overpayment. The **DHS-567, Recoupment Letter for AFC/HA**, is the form used for recoupment of an overpayment to a licensed provider. When the DHS-567 is generated in MiAIMS, the form is automatically sent to MDHHS Medicaid Collections Unit.

**Note:** If the adult services worker generates more than one form in error, then the Medicaid Collections unit must be notified with the correct request.

If the AFC is not cooperative regarding the overpayment, notification to the license consultant would be necessary as a rule violation may have occurred.

For more detailed information on the recoupment process, see **ASM-165, Overpayment and Recoupment Process**.